States will be with you. Thank you very, very much.

President Mandela. Well, goodbye, Mr. President.

President Clinton. Goodbye.

NOTE: The President spoke at approximately 9:50 a.m. from the Situation Room at the White House to Burundi peace talks participants at the International Conference Center in Arusha, Tanzania. In his remarks, he referred to President Benjamin William Mkapa of Tanzania; and Howard Wolpe, Special Envoy of the President and Secretary of State to Africa's Great Lakes region. The transcript released by the Office of the Press Secretary also included the remarks of President Mandela; however, it did not include the opening portion of the teleconference.

Remarks on Efforts To Improve Patient Safety
February 22, 2000

Thank you very much. Let me begin by thanking Barbara Blakeney for her words and her work on the frontlines of health care, and for the true visionary leadership that the nurses of our country have given efforts for health care reform, certainly for all the days that I have been privileged to be here as President, and long before.

I want to thank Secretary Shalala and Secretary Herman for the work that they have done on the whole issue of quality health care, on medical errors, and their pioneering work for the Patients' Bill of Rights.

I thank Senator Jeffords, Senator Specter, and Senator Harkin for being here. They had an important hearing today, and I can tell you that—I was talking to them for a few moments outside—they are passionately interested in and very well-informed about this issue. And as we all know, when we have a bipartisan commitment in the Congress to solving a problem in America, it normally gets solved. And I thank you all very much for your dedication.

I want to thank all the people who are here from the National Government. John of AHRQ—I like that. That's pretty good. [*Laughter*] Tom Garthwaite, Sue Bailey, Paul London, all the people here from all the other agencies who have worked so hard on this. Thank you very, very much. Thank you, Ken Kizer. I thank the leaders representing consumers, health care plans and providers, business, labor, and quality experts who are here. And of course, I want to thank the National Academy of Sciences' Institutes of Medicine for its landmark report.

As Secretary Shalala said, the IOM study focused new light on what has been a high priority of ours, which is ensuring that all Americans get the highest quality health care in the world. Secretary Herman pointed out that this is about more than saving lives—the dollar cost of—it is about more than money, and it's even about more than saving lives, because it's about the toll in lost trust in the health care system. We heard a lot about it when the IOM study came out.

But we know that if we do the right things, we can dramatically reduce the times when the wrong drug is dispensed, a blood transfusion is mismatched, or a surgery goes awry. As I have said many times, I will say again, I'm not here to find fault. I'm here to find answers.

We do have the best health care system in the world, the finest health professionals in the world. New drugs, new procedures, new technologies have allowed us to live longer and better lives. Later this year, when researchers finish the mapping of the human genome, it will lead to even greater advances in our ability to detect, treat, and prevent so many, many diseases.

But the growing advances have been accompanied by growing complexity in our health care delivery system. I might say it's complicated by the choices we have made about how we finance it and operate it. So the time has plainly come, as a result of the IOM study, to just take a step back and ask ourselves: How can we redesign the system to reduce error? Have we given all of our caregivers adequate training? Do they adequately coordinate with and communicate with one another? Do all settings have the right kinds of teams and systems in place to minimize mistakes?

These are the kinds of questions that were asked and answered in our landmark efforts as Americans to improve aviation safety and workplace safety. And if these questions are properly asked and answered in the context of the health care system, they will dramatically reduce errors there as well.

Last December I directed our own Health Care Quality Task Force to analyze the IOM study, to report back with recommendations about how we can follow the suggestions they made to protect patients and promote safety. This morning I received the task force report, and I am proud to accept all its recommendations.

Our goal is to reduce preventable medical errors by 50 percent within 5 years. Today I announce our national action plan to reach that goal.

First, we agree with the need to establish a focal point within the Federal Government to target this challenge. So today I propose the creation of a new center for quality improvement in patient safety. My budget includes $20 million to support the center, which will invest in research, develop national goals, issue an annual report on the state of patient safety, and translate findings into better practices and policies.

Second, we will ensure that each and every one of the 6,000 hospitals participating in Medicare has patient safety programs in place to prevent medical errors, including medication mistakes. These new systems save lives and over time, of course, also save money. I commend hospitals for the steps they have already taken, and we'll work with them and other health care experts to develop this regulation in the coming months.

Third, as we seek to make sure that the right systems are in place, we need to make sure they are working. Today I am releasing our plan for a nationwide, State-based system of reporting medical errors, to be phased in over time. This will include mandatory reporting of preventable medical errors that cause death or serious injury, and voluntary reporting of other medical mistakes and so-called near misses or close calls.

Reporting is vital to holding health care systems accountable for delivering quality care and educating the public about the safety of their health care system. It is critical to uncovering weaknesses, targeting widespread problems, analyzing what works and what doesn't, and sharing it with others.

Twenty-one States already have mandatory error reporting systems. We want to make sure they have the tools to do it right, and that every other State will follow suit. That's why we'll be working with the National Quality Forum, a private-public group of health care experts, to develop a set of patient safety measurements that would lay the foundation for a uniform system of reporting errors.

We also want to replace what some call a culture of silence with a culture of safety, an environment that encourages others to talk about errors, what caused them, and how to stop them in the first place. So we'll support legislation that protects provider and patient confidentiality, but that does not undermine individual rights to remedies when they have, in fact, been harmed. People should have access to information about a preventable medical error that causes serious injury or death of a family member, and providers should have protections to encourage reporting and prevent mistakes from happening again.

And when it comes to reporting, we want the Federal Government to continue to lead by example. The Department of Veterans Affairs already has a mandatory reporting system for death and serious injuries. Beginning this spring, all 500 Department of Defense hospitals and clinics will do the same. And the VA will add a voluntary reporting system in its hospitals nationwide.

Finally, I'm announcing a number of new steps we will take that specifically target medication errors. Each year, medication mixups claim thousands of lives. Sometimes mistakes occur because many different drugs sound or look the same, sometimes because people are taking multiple medications and going to multiple doctors.

I'm calling on the Food and Drug Administration to develop new standards to help prevent medical errors caused by drugs that sound similar or packaging that looks similar. In addition, we'll develop new label standards that highlight common drug interactions and dosage errors. The VA will also put in place computerized systems to prevent medication mistakes; no more handwritten prescriptions that no one can read.

Hospitals that have already taken these steps have eliminated—listen to this—two out of three medication errors. This is very significant. We tend to think all of our problems are the result

of some complex, high-tech glitch. We just want to make sure people can read the prescriptions. Two out of three of these errors can be eliminated.

Taken together, these actions represent the most significant effort our Nation has ever made to reduce medical errors. It's a balanced, commonsense approach based on prevention, not punishment; on problemsolving, not blame-placing.

If we can do this and pass a strong, enforceable Patients' Bill of Rights, we will have gone a long way toward ensuring quality health care for all Americans in the 21st century. Just think about it. We can cut preventable medical errors in half in 5 years, reduce concerns about lawsuits and about medical mistakes, avoid needless injuries and deaths, save lives, and make the world's best health care system much better for all Americans.

This is a worthy endeavor. It is one that, as you see, will be bipartisan, and one that I am committed to seeing through. Thank you all for being here, and let's get about the business of doing this.

Thank you.

NOTE: The President spoke at 12:53 p.m. in Presidential Hall in the Dwight D. Eisenhower Executive Office Building. In his remarks, he referred to Barbara A. Blakeney, first vice president, American Nurses Association, who introduced the President; John M. Eisenberg, Administrator, Agency for Healthcare Research and Quality; and Paul A. London, Senior Policy Adviser to the Secretary, Department of Commerce.

Remarks at a Reception for Lieutenant Governor Ruth Ann Minner of Delaware

February 22, 2000

The President. Thank you very much, Lieutenant Governor Minner, Senator Biden, ladies and gentlemen. I was sitting here looking at all of your faces, and I reached over and whispered to Joe Biden, I said, "You know, I really like Delaware." [*Laughter*] It has certain unique parallels to my home State. It's two of the places in America where there are more chickens than people. [*Laughter*] And depending on what day it is, that's not all bad. [*Laughter*]

I am profoundly grateful to Delaware for many reasons. You have been so good to me and to Al Gore. Twice you have given me your electoral vote; you supported the Vice President, for which I am very grateful. I couldn't even begin to tell you, in the time I have allotted tonight, all the reasons for my gratitude, respect, and affection for Senator Biden.

Senator Joseph R. Biden, Jr. Go ahead and tell them. [*Laughter*]

The President. Beginning with his uncommon humility. [*Laughter*] His retiring personality. [*Laughter*] His always muted voice. [*Laughter*] Actually, if you're looking for somebody in American politics who understands what life is like for ordinary people, who's always there to defend the Constitution of the United States, and understands the rest of the world—in other words, the three big things you've got to do if you're a Senator—there is nobody in the Senate who can do all three as well as Joe Biden. You are very well served.

And the third thing I'd like to say is, I'm also grateful to your Governor for a lifetime, nearly, it seems like, a political lifetime of friendship and all the work we've done together on welfare reform, on strengthening families, on child support enforcement. I'm elated that he's running for the Senate. And I look forward to his success and to his service.

The fourth reason I'm here is, this is my year to support women for elected office. I'm into that. I think we ought to do more of that. [*Laughter*] Hillary tried to call me right before I got here. She's up in New York and coming home tonight. And I would imagine she was trying to call me before I got here to say that she thinks you guys ought to stick together—[*laughter*]—and so do I.

But let me tell you, finally, I'm here because I really admire Ruth Ann Minner. I really admire Ruth Ann Minner. Some of you know this, but I was born to a widowed mother who had to leave to go back to school. I can only imagine